**APPENDIX 15**
**Notice of Adoption as Filed with OAL**

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35 N.J.R. 11(2)

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INSURANCE
DEPARTMENT OF BANKING AND INSURANCE
DIVISION OF INSURANCE

Health Benefit Plans
Prompt Payment of Claims
Organized Delivery Systems; Reports

Proposed: June 2, 2003 at 35 N.J.R. 2394(a)

Adopted Amendments: N.J.A.C. 11:22-1.1, 1.2, 1.9 and 1.10

Adopted: , 2003, by Holly C. Bakke, Commissioner
Department of Banking and Insurance

Filed: , 2003 as R. 2003 d. , **with substantive changes** not requiring additional public notice and opportunity for comment (See N.J.A.C. 1:30-6.3)

Authority: N.J.S.A. 17:1-8.1, 17:1-15e, 17B:30-13.1, 17B:30-23 et seq. and 26:2J-15b

Effective Date:

Expiration Date: November 6, 2005

**Summary** of Public Comments and Agency Responses:

The Department of Banking and Insurance (Department) received written comments from the following: Bacharach Institute for Rehabilitation, Health Insurance Association of America, New Jersey Hospital Association, Monmouth Medical Center and Magellan Behavioral Health.

COMMENT: One commenter recommended that Medicare Supplement insurance coverage be specifically exempted from the rules' audit reporting requirements. The commenter stated that the majority of Medicare Supplement claims are adjudicated automatically and are typically reimbursed within 48 hours. The commenter stated that due to the electronic submission, no claim examiner intervention exists. Additionally, the commenter stated that these claims are

"triggered" by Medicare. The reporting of these claims accurately is not reflected in the detail of information requested in Appendix B. The commenter suggested that the Department consider utilizing "health benefit plans" as defined in N.J.A.C. 11:4-23A.2 in determining whether an exemption should be requested or granted with respect to the annual premiums earned by an insured. The commenter asserted that the elimination of these requirements would relieve carriers of the administrative burden that will result from preparing, and save the Department time and resources spent on reviewing, an unnecessary report.

RESPONSE: The Department disagrees with the commenter. The authorizing statutory provision does not exclude Medicare Supplement insurance coverage from the audit reporting requirements.

COMMENT: Two commenters expressed concern with N.J.A.C. 11:22-1.2(b) and the addition of a definition of "organized delivery system." The commenters stated that the Department's rules at N.J.A.C. 11:22-1.1(b), "purpose and scope," state that these requirements apply to insurance companies, health maintenance organizations, and health service corporations, among others, as well as their agents. The commenter noted that this section does not state that these rules apply to ODSs. The commenter stated that while ODSs would currently be covered under the rule by virtue of being a payer's subcontracted agent, the commenter believes that once an ODS is licensed or certified (pursuant to requirements recently established by both DOBI and the Department of Health and Senior Services) it will no longer be acting as a payer's agent, but as a healthcare payer in its own right. Therefore, the commenter believes that section 1.1(b) must be amended to explicitly state that these rules apply to ODSs. The commenter stated that simply adding a definition of ODS to section 1.2 does not require the entity to comply with these rules.

The commenter stated that a failure to ensure that these rules explicitly apply to ODSs in this manner may render the proposed amendments regarding reporting requirements moot.

RESPONSE: The Department concurs that some clarification of N.J.A.C. 11:22-1.2 is desirable, but does not agree with the observation that the current provision does not indicate that these rules apply to ODSs. N.J.S.A. 17B:30-26 was amended by P.L. 2001, c.67 to add a definition of ODS and to amend the definition of "payer" to include "an organized delivery system or any agent thereof" which is doing business in the state and is under contractual obligation to pay insured claims. The Department notes that N.J.A.C. 11:22-1.1(b) currently provides that this chapter applies to any insurance company, health service corporation … and to any "agent", employee or other representative of such entity that processes claims for such entity. The term agent is defined in N.J.A.C. 11:22-1.2 to mean: "any entity, including a subsidiary of a carrier, or an organized delivery system as defined by N.J.S.A. 17:48H-1 with which a carrier has contracted to perform claims processing or claims payment services." The Department further notes that N.J.A.C. 11:22-1.3 through 1.6 each begin by referring to "A carrier and its agent," or to "A carrier or its agent." As a result, the term "agent" as used in these provisions clearly includes organized delivery systems. Nevertheless, in an effort to eliminate any ambiguity, the Department is amending N.J.A.C. 11:22-1.1(b) upon the adoption of these amendments by adding the term "organized delivery system" to its description of the purpose and scope of the chapter, and to further clarify that N.J.A.C. 11:22-1 et seq. applies to organized delivery systems.

COMMENT: One commenter stated that it would like clarification of N.J.A.C. 11:22-1.9 as it pertains to the submission by the carrier or their agents or both.

RESPONSE: The carrier and the ODS should decide who will provide the necessary reporting information required by the Department. This agreement should be spelled out in the contract between the parties.

COMMENT: One commenter stated that the proposed rule should amend the reporting requirements found at N.J.A.C. 11:22-1.9 by allowing carriers and ODSs to obtain an exemption from having the annual report audited if the payer filed its quarterly and annual reports by the deadlines established for each and its annual premiums were less than $5 million in the year covered by the annual report. The commenter stated that payers that qualify for the exemption are also exempt from filing quarterly reports for the following year. The commenter believes that under the current provision, no carrier currently licensed in New Jersey would meet the conditions necessary in order to qualify for an exemption, given that they each receive well over $5 million in annual premiums. However, ODSs will likely qualify for the exemption and, consequently, avoid having to submit audited prompt pay reports.

RESPONSE: The Department disagrees with the commenter. There are a number of carriers with small premium volume in this State that could qualify for the exemption at this time. The Department has no basis for believing that ODS's will qualify for the exemption, but those that do, if any, will have a small volume of business.

COMMENT: Two commenters stated that they are opposed to any provision that would allow an entity responsible for the payment of claims to avoid regulatory oversight of their claims payment practices by submitting unaudited claims payment reports. The commenter suggested that the Department, in determining whether to grant the filing exception, only considers the size of the payer and whether it submitted quarterly reports on time. The commenter stated that there is no mechanism in place for verifying that the reports submitted are accurate and represent a true account of a payer's claims processing and payment practices.

The commenters contended that under this provision, payers could effectively avoid oversight for two years, as quarterly reports submitted in the first year may be inaccurate, but if filed timely, would allow the payer to receive an exemption from submitting quarterly reports in the second year following adoption of this provision. The commenter believes that this is unacceptable, especially in light of the fines recently assessed by the Department in response to prompt pay violations found during its audit of claims for several payers. The commenter stated that the number of enforcement actions undertaken by the Department demonstrates that the need exists for continued monitoring of payers' claims processing practices. The commenter stated that it learned in its review of the reports that auditors found reporting discrepancies by all but one payer. Ensuring by objective, independent means the accuracy of the reports submitted is essential if the reports are to have any value to the Department.

The commenter stated that because ODSs have, until now, been serving as payers' agents, a providers' recourse for recovering late or no reimbursement was to go after the carrier. Once ODSs are certified and licensed, a provider's only recourse will be to file an appeal as required elsewhere in the prompt pay regulations. The commenter stated that there is no reason

to believe that ODSs' practice of slow pay will change; and that the only way to truly monitor their compliance with the requirements is to require the submission of audited annual reports.

RESPONSE: The Department disagrees with the comment. Carriers that would, under the rule, not file certain reports because of their size are still subject to oversight, including the filing of unaudited reports, investigation and enforcement of complaints, and market conduct examinations. The rule as proposed only allows exemptions for carriers of a certain size who file timely reports. Reports are reviewed by the Department, so the audit is not the sole determinant of the accuracy of the reports.

The commenter notes that fines have been assessed against carriers for prompt pay violations. The rule as proposed would have had no impact on the Department's monitoring activities, because the carriers in question were too large to meet the exemption requirement, and because the fines were the result of a market conduct examination, not an "audit" of the claims paying practices.

The commenter states that, once ODS's are certified and licensed, providers will have no recourse against the carrier for prompt pay violations. This comment does not address the proposal, which concerns only reporting requirements and does not address the question of responsibility. However, the Department disagrees with the statement that a carrier who contracts with a licensed ODS has no responsibility for the prompt payment of claims by that ODS. Only an ODS with a very small volume of business could be exempted from some reporting requirements. As noted above in the case of carriers, such an exemption does not mean that the oversight of claims payment practices would be eliminated for such exempt ODSs.

These comments, taken together, imply that through this rule the Department is attempting to significantly weaken the oversight of prompt payment of claims. The Department's intention is precisely the opposite. The vast majority of health claims, and health claim payment problems, can be attributed to fewer than 25 companies that account for almost all of New Jersey's market. The Department believes that its limited resources would be best utilized in investigating and monitoring these carriers.

**Full text** of the adoption follows ( additions to proposal indicated in boldface with asterisks ***thus*;** deletions from proposal indicated in brackets with asterisks *[thus]*.)

11:22-1.1 Purpose and scope

(a) (No change.)

(b) This chapter applies to any insurance company, health service corporation, medical service corporation, hospital service corporation, health maintenance organization, dental service corporation and dental plan organization that issues health benefit plans or dental plans in this State; ***any organized delivery system;***and to any agent, employee or other representative of such entity that processes claims for such entity.

10/14/03
Date

Holly C. Bakke
Commissioner

DHT03-12/INOREGS